Caring for Bereaved Patients
"All the Doctors Just Suddenly Go"

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. . . our sorrow lives in us as an indestructible force, only changing its form . . . and passing from pain into sympathy—the one poor word which includes all our best insight and our best love.
George Eliot, Adam Bede[1]

Despite the frequency with which physicians encounter bereaved patients, medical training offers little guidance in the provision of bereavement ("after") care. Physicians are often uncertain of how to distinguish between normal and pathological grief reactions in their bereaved patients, and how to manage their health care. Bereavement is associated with declines in health, inappropriate health service use, and increased risk of death. Identifying and intervening on behalf of bereaved patients could help address those increased risks. We examine the experience of a woman widowed for 2 years to illustrate distinctions between symptoms and outcomes of uncomplicated and complicated grief, recommend approaches to physician interactions with bereaved patients, and offer guidelines for professional intervention in aftercare.

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THE PATIENT'S STORY

Mrs A, a longtime patient of Dr M, is 77 years old and has been widowed for 2 years. Her husband, a well-respected public figure, died in December 1998 after a protracted course of diabetes, hypertension, coronary artery disease, congestive heart failure, end-stage renal disease, and, ultimately, renal failure. The husband, who was not Dr M's patient, had been cared for at home by Mrs A until his final 10-week hospitalization, which involved repeated admissions to the intensive care unit. One of their sons moved into their home temporarily to help care for his father, while another son and a daughter live nearby.

During the first year of widowhood, Mrs A visited Dr M more than usual—roughly every other month. Her visits were nominally to address somatic complaints (eg, insomnia, perpetual weeping). It was clear to both Mrs A and Dr M that bereavement was the major source of these problems, so much of the time was spent addressing that explicitly. Dr M offered a sleeping pill, which she declined. Mrs A began seeing a psychiatrist and attending a bereavement support group. She was interested in obtaining additional information about grief and bereavement, including written material and Web resources.

PERSPECTIVES

Mrs A and Dr M were each interviewed by a Perspectives editor in December 2000.

MRS A: *Immediately following my husband's death there was constant pain. I did things, but it was very difficult; he was in my mind all the time. I was running videos of his last days in my head—everything that had happened in his care, and how he reacted, and what the doctors were doing with him—it was not a very good way to die. I also felt numb . . . . It's hard to recall what happened and why I made certain decisions. I was depressed and couldn't sleep well. And I cried. I've never cried as much as I cried for the first few months after he died. I still cry when I think about it . . . . I'll never get rid of that pain. I know there is anecdotal evidence that if people had cancer, it can recur after a spouse or a partner or a child's death. I've had cancer 3 times and I didn't want that to happen again. That's one reason I really worked at trying to get myself steady.*

DR M: *I saw Mrs A about 3 weeks after her husband died. I reassured her that grief resolution takes time. I told her that grief was like a long tunnel, which she had entered suddenly, and that she was now in the dark, but that she would eventually emerge back out into the light. But I said that just like when you come out of a tunnel, things are different on the other side. She seemed to understand. When I saw her in November 1999, she complained of insomnia and had a lot of other somatic complaints. I noticed the date and I told her that she might reexperience intense grief again, around the time of the anniversary of her husband's death. In the following year, I saw her only 3 or 4 times. She was no longer tearful in the office. She*

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was beginning to go out more, and to travel, and she made some new friends.

WHY PHYSICIANS SHOULD PLAY A ROLE IN BEREAVEMENT CARE

Although they may not always recognize it, physicians care for many distressed, ailing, bereaved patients. Loss through death is a common[2] and extremely stressful[3,4] experience. Bereavement heightens a person's risk of depressive syndromes[5,6]; sleep disruption[7]; increased consumption of tobacco, alcohol, and tranquilizers[8,9]; suicide attempts[10,11]; and mortality.[12,13] A comprehensive recent review[14] concluded that "the health of bereaved people in general is at risk (compared to their non-bereaved counterparts)." The authors continue that high risk "has by now been well established. There is no longer any doubt that the costs of bereavement in terms of health can be extreme."

As exemplified by Mrs A, widowed people visit physicians more than they had when they were married—even after adjusting for age, sex, and socioeconomic and health status.[15] Bereavement tends to occur most often in later life,[2] when health and adaptive capacities may already be compromised. Consequently, the aging of the US population[2] implies that physicians will devote an increasingly large percentage of time to caring for grief-stricken patients.[16]

DIFFERENCES BETWEEN UNCOMPLICATED AND COMPLICATED GRIEF

Uncomplicated Grief

Normal, or *uncomplicated*, grief reactions are those that, though painful, move the survivor toward an acceptance of the loss and an ability to carry on with his or her life.[17-20] Indicators of normal adjustment include the capacity to feel that life still holds meaning, a sustained sense of self, self-efficacy, trust in others, and an ability to reinvest in interpersonal relationships and activities.[17-20] Despite her distress over her husband's death, Mrs A's grief appears uncomplicated: she accepts her husband's death, her grief symptoms have attenuated, she is involved with her family and has made new friends, she is engaged in civic pursuits, and she works to maintain her health.

Complicated Grief

In 1944, Lindemann[19] described features of "morbid grief reactions" (eg, ruminations about the deceased, hostility) that he viewed as deviations from "normal" grief and that required more aggressive intervention. Consistent with Lindemann's observations, recent research demonstrates that bereaved individuals with high levels of complicated grief symptoms have substantially greater dysfunction than those with lower levels of these symptoms.[16,21-25] Studies find that complicated grief symptoms: (1) form a coherent cluster of symptoms distinct from bereavement-related depressive and anxiety symptom clusters (ie, the underlying phenomenology of the symptoms indicates they constitute separate syndromes)[21-26]; (2) endure several years for some bereaved subjects[21,22,26]; (3) predict substantial morbidity and adverse health behaviors over and above depressive symptoms (eg, cardiac events,[22] high blood pressure,[16,22] cancer,[22] ulcerative colitis,[19] suicidality,[21,22] social dysfunction,[19,23,25,26] anergia,[19,23,25,26] changes in food, alcohol, and tobacco intake,[22] and global dysfunction[16,22-24,26]); and (4) unlike depressive symptoms, are not effectively reduced by interpersonal psychotherapy and/or tricyclic antidepressants.[27,28] These findings revealed a need to identify and treat complicated grief as a psychiatric disorder distinct from major depressive disorder (MDD).

Responding to this perceived need, a panel of leading experts in psychiatric reactions to loss and trauma, depression, sleep disorders, and psychiatric taxonomy met to evaluate the studies just described and, if the evidence justified it, develop diagnostic criteria for complicated grief (**TABLE 1**) (details of the consensus conference on traumatic grief, as complicated grief was referred to at that time, are provided elsewhere[29,30]). These diagnostic criteria do not constitute an official psychiatric diagnosis and do not appear in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (*DSM-IV*), but the panel deemed the evidence to be strongly supportive of complicated grief as a separate psychiatric disorder (ie, distinctive symptoms, risk factors, course, treatment response, and outcomes).[29,30]

Diagnostic Algorithm for Complicated Grief

The published refinement of the complicated grief criteria set[29] was found to be highly sensitive and specific—that is, the diagnostic algorithm correctly classified 93% of the predetermined "cases" (true positives) and 93% of the predetermined "noncases" (true negatives) of complicated grief.[29] In addition, those diagnosed with complicated grief according to this algorithm have been shown to have significantly greater impairment (eg, high blood pressure, functional disability)[16,23] than those not meeting the proposed criteria. Additional (unpublished) analyses of the refined complicated grief criteria set indicated that 6-month symptom duration was superior to the 2-month duration specified earlier, with respect to the reduction in the number of false positives and to enhanced predicitive validity. For this reason, we present a modified version of the diagnostic algorithm[29] and use the case of Mrs A to illustrate its application (Table 1).

To receive a diagnosis of complicated grief, a bereaved patient must first meet the necessary conditions outlined in criterion A (extreme levels of 3 of the 4 "separation distress" symptoms, such as yearning for the deceased). If criterion A has been met, then criterion B (extreme levels of 4 of the 8 "traumatic distress" symptoms, such as numbness, feeling that part of oneself has died, assuming symptoms of the deceased, disbelief, or bitterness) must be met. If the bereaved patient's symptoms in criteria A and B endure for 6 months or longer (criterion C) and these symptoms are

linked to substantial functional impairment (criterion D), the individual satisfies the criteria for complicated grief.[16,23,29,30]

Shock

Despite the fact that their grief is uncomplicated, patients like Mrs A are often unprepared for how profoundly they are affected by their loss. They frequently feel surprised by how much turmoil and pain (sometimes described as psychic trauma) bereavement brings.[26,31,32] Bereaved patients may report feeling incredulous about the death.[22,23,26,31,32] Immediately after her husband's death, Mrs A described a mild state of shock and confusion. She had difficulty remembering the events culminating in her husband's death, in understanding her own actions, and she felt emotionally numb. C. S. Lewis[33] poignantly described this as an "invisible blanket between the world and me." By 2 years post-loss, Mrs A's initial numbness and detachment from others appear to have subsided (she describes numbness in the past tense; she has made new friends). Bereaved patients who appear disoriented, are in a quasi-dissociative state, functioning on "automatic pilot,"[14,26,29] reflect their extreme difficulty in emotionally and cognitively processing the loss. Remaining markedly stunned or dazed at 6 months post-loss is a telling symptom of complicated grief.[29]

Separation Distress

Mrs A describes the pain of grief, including the symptoms of separation distress[17,18,26,29,33]: intrusive, intermittent yearning and thoughts about the deceased. Even highly functioning people may become transiently distraught and disabled by a preoccupation with the loss.[18,26,33] By 6 months post-loss, however, most bereaved people begin to experience an abatement of the acute separation distress symptoms.[22,23,34] Dr M noticed that in the year following her husband's death, Mrs A was crying less as well as socializing and traveling more, suggesting she was neither depressed nor otherwise impaired by ruminations about her husband's death (and therefore she would not meet complicated grief criterion A).

Denial of the Death and Avoidance of Change

MRS A: *I haven't been [to the grave site]. I can't. The thought of it is painful. I have pictures of him all over and I can't dispose of his suits. I can't do that without the help of my kids.*

Table 1. Does Mrs A Meet Criteria for Complicated Grief at 2 Years Post-Loss?

Diagnostic Criteria*	Does Mrs A Meet Criterion?
Criterion A Person has experienced the death of a significant other and response involves 3 of the 4 following symptoms, experienced at least daily or to a marked degree	
Intrusive thoughts about the deceased	Yes, seems marked
Yearning for the deceased	Yes, seems marked
Searching for the deceased	Scans for clues or messages from deceased husband, but not to a marked degree
Excessive loneliness since the death	Not mentioned, which is unusual
Criterion A met?	Unlikely
Criterion B In response to the death, 4 of the 8 following symptoms experienced at least daily or to a marked degree	
Purposelessness or feelings of futility about the future	Not to a marked degree (see criterion D)
Subjective sense of numbness, detachment, or absence of emotional responsiveness	Initially yes, but no evidence that she continues to be numb
Difficulty acknowledging the death (eg, disbelief)	No
Feeling that life is empty or meaningless	No (see criterion D)
Feeling that part of oneself has died	Not mentioned
Shattered worldview (eg, lost sense of security, trust, control)	No
Assumes symptoms or harmful behaviors of, or related to, the deceased person	No
Excessive irritability, bitterness, or anger related to the death	Irritated about husband's terminal care, but further probes needed to determine whether excessive or not
Criterion B met?	No
Criterion C Disturbance (symptoms listed) must endure for at least 6 months	Not at marked levels
Criterion D The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning	No, very active and engaged in activities that are meaningful to her (son's campaign, organized conferences); formed new relationship with male friend; exercises
Does Mrs A meet criteria for complicated grief?	No

*Modified version of traumatic grief criteria published previously.[29] Modifications were based on results emerging from recent unpublished analyses to determine the most diagnostically sensitive and specific set of criteria for complicated grief (complicated grief was formerly called traumatic grief).

Mrs A's reluctance to visit her husband's grave and to part with his possessions suggests an aversion to things signifying her permanent separation from him. Although some researchers suggest that avoidant coping reflects a patient's difficulty in accepting and adapting to the loss,[19,35,36] others claim it may be adaptive in the long term.[37,38] Analyses of symptoms that define complicated grief reveal avoidance to be one of its weakest indicators; hence, avoidance was omitted from the refined criteria set for complicated grief.[29,39] Irrespective of whether bereaved people avoid reminders of the death, those who are unable to accept the death and make changes in response to new situational demands would appear vulnerable to social and occupational dysfunction[29,35] (complicated grief criterion D). This does not appear to be the case for Mrs A, who appears able to accept the death and to function reasonably well.

Anger

MRS A: *We haven't approached the way he died. It was absolutely disgusting . . . that pushing him constantly as to whether he wanted heroic measures of care. We had a lot of irritation. It was insensitive. He had made his wishes clear—he did not want valiant measures.*

Anger and protest over a significant loss are a part of grief.[18,19] Bereaved patients may even feel anger toward the deceased for perceived abandonment.[18,26] Hostility is often directed at the deceased patient's physician or the health care system for failing to provide what they consider to be adequate care for their loved one.[19,40] Mrs A is irritated about the care her husband received and might well meet complicated grief threshold levels for bitterness, although she does not appear consumed by rage as many patients are with complicated grief[19,26] (see **TABLE 2** for ways physicians might diffuse anger directed at them).

Guilt

MRS A: *I feel very guilty myself. I spent over 2 months in the hospital with him. But the particular night that he died, I didn't stay up there. I'm not sure I'll ever get over that guilt. You think about the things you did wrong in the illness or in the marriage, and there's nothing you can do about it now. Although I did many good things, obviously. But that one night is going to haunt me for the rest of my life.*

Like Mrs A, surviving family members may feel passing guilt over what they did or did not do for the deceased.[19,41] When pervasive self-reproach and survivor guilt become part of the clinical picture, the person may be experiencing depression[20] and potentially may be suicidal.[10,19-21]

Depressive Symptoms

Mrs A complains of sadness, guilt, and insomnia. For her and most bereaved people, however, these depressive symptoms are usually transient and not numerous. Many survivors meet criteria for MDD in the first few months post-loss,[5,6,22] with a minority having persistent depressive syndromes beyond the first year (eg, 42% at 1 month, 16% at 1 year).[6]

The Course of Grief

MRS A: *There's nothing different about the phases. . . . I still find it very difficult to deal with, but it is ameliorating a bit. . . . The anniversary dates are all terrible . . . but the pain was not as bad this year as it was last year.*

There has been a growing recognition[4,42] that grief does not progress neatly through the proposed stages[17,18] of (1) numbness and outbursts of distress and/or anger, (2) yearning and searching, (3) disorganization and despair, and (4) reorganization and recovery. The Institute of Medicine cautioned against the use of the term "stages" because such use "might lead people to expect the bereaved to proceed from one clearly identifiable reaction to another in a more orderly fashion than usually occurs."[4] "Pangs of grief"[19]—the intrusive, time-limited intense yearning and pining for the deceased—may come and go in waves for years after the loss.[17,19] As in the case of Mrs A, these experiences typically attenuate in intensity and frequency, becoming more bittersweet than painful. For some individuals, however, grief remains chronic and severe. Intense grief (that meeting criteria for complicated grief) lasting 6 months post-loss and beyond has been shown to predict enduring dysfunction.[16,22-24]

PHYSICIAN CONTACTS WITH BEREAVED PATIENTS

When the Bereaved Is Not Your Patient

During the often intense last few weeks of life, the physician not only cares for the patient, but often for the spouse and family. However, after the patient has died, the family continues to need contact from the physician.

MRS A: *My husband's doctor . . . as soon as [my husband] died, that was the end of him. That's one of the things that I object to: all the doctors just suddenly go . . . there's no support. If I felt like [my husband's] physicians had enough respect and affection for me and would call me occasionally, that would be nice. Dr M and I talked, but it's not his responsibility to support me; my husband's doctor should have been there.*

Mrs A resents that her deceased husband's physician did not call her after his death. A telephone call, condolence letter, or visit shortly after the death is usually welcome.[43,44] According to Bedell et al[44]: "A physician's responsibility for the care of a patient does not end when the patient dies. There is one final responsibility—to help the bereaved family members. A letter of condolence can contribute to the healing of the bereaved family. . . ." A follow-up contact with surviving family members acknowledges the loss, expresses sympathy and concern, and offers an opportunity to clarify questions about the patient's terminal care.

When the Bereaved Is Your Patient

In the first couple of months post-loss, the physician might telephone to offer condolences and also to recommend a visit

Table 2. Strategies for Communication With and Caring for Bereaved Patients

Things to say. . .	Because. . .
I'm sorry, or I'm sorry she/he's gone.	Acknowledges the loss and lets the bereaved person know you feel for them. Not saying this much is often perceived as a lack of respect or concern.
I can't imagine what you're going through.	Bereaved patients are often frustrated by people who minimize or assume they know how they are feeling. No one can fully understand another's loss and admitting this is appreciated.
What are you remembering about [the deceased] today?	Bereaved patients are always remembering the deceased. Don't worry about bringing up sad memories–they are there. Help them to express their thoughts and they will feel like you care. They will appreciate your interest.
Say [deceased's] name.	Bereaved patients will never forget the deceased. Let them know you won't forget him/her either by mentioning his/her name.
Talk about the deceased. Depending on your relationship to the deceased, you may want to say it was an honor to know him/her and that you will miss him/her.	Bereaved patients worry that others, and even they, will forget the uniqueness of the deceased. Talking about the deceased helps keep everyone remembering. If you did not know the deceased person, acknowledge that and express regret.
Do you have any questions about the final illness and treatment?	Most bereaved people are extremely interested to know about the events leading up to the death and many have unanswered questions that have bothered them. Providing a response may help to provide closure.
How are you feeling since [the deceased's death]? How has [the deceased's death] affected you?	Bereaved patients will appreciate the concern and this may save time by getting to the reason or need for the visit.
Things Not to Say	**Because. . .**
Call me.	Passive effort puts the burden on the bereaved person. A sincere effort is to make a personal call to the bereaved patient.
How are you? (casually)	Only if you have time to listen. If not, don't ask.
I know how you feel.	It seems presumptuous for anyone to claim to know how another person feels.
It was probably for the best.	A bereaved person does not view it this way.
[She/He's] happy now.	You have no way of knowing this and the patient may resent your presuming to know.
It is God's will.	Those who are in mourning typically protest. Saying God wanted it this way may confuse the religious and offend the nonreligious.
It was his (or her) time to go.	Bereaved patients have trouble seeing it this way. Those in mourning protest their loved one's departure and almost never think the time was "right." However, if you see that they are tormented by what they did or did not do to prevent the loss, it may be in order to say that there are things that are not within anyone's control.
I'm sorry I brought it up.	Don't be sorry; bring it up. Bereaved patients want you to know about their loss.
Let's change the subject.	Don't change the subject. Bereaved patients want to talk with you about their loss.
You should work toward getting over this by now.	Bereaved people never "get over" their loss, but learn to live with it. Putting pressure on them to "move on" is, in a sense, blaming them for their continued grief, may instill guilt, and add to their concerns. If grief is prolonged, it may be time for a referral for expert help.
I had another patient who had the same illness [as the deceased] and he suffered for a long time. You should be glad [the deceased] passed away quickly.	Though some may find comfort in this comparison, others will not because they feel that it doesn't matter how long a loved one suffered, it matters that she/he did. Safer to avoid these sorts of comparisons.
You're strong enough to deal with it.	Mourning is about the loss and not about the mourner's strength. A more appropriate response might be to say to the bereaved, "I hope you find the strength to bear your loss."
Practices to Implement	**How. . .**
Death notification	Try to establish a system whereby you are notified of patient deaths, recent losses, and deaths within patient's families. Encourage patients, colleagues, and funeral directors to notify you if there has been a death in the family, and/or have patients complete a brief form while in the waiting room that asks about recent losses.
Outreach–express sorrow, invite discussion, schedule visit, and monitor symptoms	Once notified of a death, have staff contact bereaved patients to acknowledge loss, see how they are doing, and encourage a scheduled visit.
Have useful information available	Provide a list of resources for bereaved patients. Make available information on literature and Web sites, support groups, clergy, mental health professionals, lawyers, and financial planners.
Practices to Avoid	**Because. . .**
Passivity	Try not to be passive, vague, or insincere. Refrain from asking bereaved patients to take the initiative, thereby putting the burden on them.
Avoidance	Bereaved patients want you to know that they recently lost a significant person in their life. They typically want you to know how this upsets them and want to talk about it with you. To avoid their grief denies them an opportunity to express and address their concerns, and may obscure the real reason for their visit.
Making comparisons with other losses	Try not to compare one person's loss with other patient deaths or deaths in your family. If handled well, empathy may provide some solace and acknowledging that it could be worse may minimize regrets, but comparisons run the risk of minimizing the significance of an individual's loss.
Pressure and inappropriate positivity	Avoid encouraging them to put the past behind them. Try not to imply that they should be making larger strides towards moving forward with their life. Do not try to locate them on a linear grief trajectory, place them in a stage of grief, or suggest their outlook be more positive.

to evaluate and then monitor the survivor's health care needs.[43] The content of office visits might shift from ordinary practice to a discussion about the course of grief—as Dr M and Mrs A's interactions illustrated—symptoms indicating a need for professional intervention (eg, complicated grief, MDD, suicidality) and behavioral recommendations (Table 2).

What to Say and Do

Reluctance on the part of physicians to approach the deceased patient's survivors may stem from their perception that the family is angry with them, and perhaps from a sense of guilt and/or helplessness about being unable to prevent the death. In a study of reactions to terminal care, 30% of surviving family members reported dissatisfaction with the information provided about the cause of death.[45] Main[43] found that bereavement outcomes can be significantly influenced by communication and the quality of information given to survivors. Physicians who contact bereaved patients and express sorrow and concern may minimize the anger directed toward them.[43,44]

The physician's discomfort or uncertainty about what to say or do when encountering a bereaved patient must be overcome in favor of taking active steps to help them. A list (Table 2) of comments and practices in communicating with and caring for grieving patients has been derived from a synthesis of discussions with widowed persons, participation in grief support groups, and suggestions offered by various Web sites.[46,47]

FACILITATING HEALING AMONG BEREAVED PATIENTS

Social Support

MRS A: *I started going to a support group about a week after my husband died, and I go to it still. And also, about a year ago, I met a very nice gentleman. I just did it at first because I thought this was a very sensible thing to do. I really didn't care to do it. But he's very good to me. I think one thing one misses tremendously is touching . . . everybody needs warmth from another person.*

Research confirms that empathic friends may afford a great deal of comfort.[48] The benefits derived from developing new romantic interests[49] and participation in support groups[50] have also been demonstrated. Hence, encouraging these sorts of social activities would appear a sound practice.

Developing New Routines and Skills

MRS A: *I wonder what happens to the regular person who's out there, whose whole way of life has to change, and who has no experience maintaining a household. If I had gone before my husband, it would have been a disaster . . . .*

For women, a primary mechanism linking widowhood to depressive symptoms is financial strain, while for men, it is the strains of household management.[51] Thus, attempts to minimize the sources of strain (eg, learning to cook or to manage money, possibly seeking employment) might reduce the risk of MDD and related mental and physical disorders (complicated grief, high blood pressure).

Maintaining an Active Daily Routine

MRS A: *I've kept myself very busy. I'm very involved in civic activities and am on a number of commissions nationally on alternative and integrative medicine and on breast cancer. I exercise daily.*

Two studies of elderly subjects found that bereaved persons who maintained a busy, daily rhythm of activity had better sleep[52] and fewer depressive symptoms than those with less active, structured schedules.[53] Mrs A's civic involvements and exercise regimen structure her day and provide her with a sense of purpose. Bereaved patients may derive similar benefits from staying involved and keeping regularly active.

Narrative Disclosure

Putting upsetting experiences into words, including disclosure about emotions in response to the death of a spouse, is associated with improved physical and mental health.[54,55] Written and oral disclosure studies have even demonstrated a positive influence on immune function.[55] Based on these findings, physicians might encourage bereaved patients to express their thoughts and feelings about the loss (eg, in a journal).

WHEN SHOULD A PHYSICIAN INTERVENE AND/OR MAKE A PSYCHIATRIC REFERRAL?

MRS A: *I went to a psychiatrist who unfortunately has now just died himself. He thought I did really well with handling this. I don't think I was ill. I didn't have that much of a depression. I was simply depressed.*

Although Mrs A's distinction between "a depression" and "simply depressed" may appear subtle, it is an essential clinical determination. In the absence of a structured clinical interview, it is difficult to determine if Mrs A had MDD. Because we suspect she did not, based on what she has said, and also doubt that she met criteria for complicated grief (Table 1), we believe referral to a psychiatrist was not necessary in her case.

When psychiatric complications are suspected, primary care physicians must begin diagnosis and treatment or refer for expert consultation and intervention. While some argue for early intervention for MDD[56] regardless of bereavement status, Horowitz et al[57] recommend that diagnosis and treatment for pychiatric disturbance(s) among bereaved patients occur beyond a year after the loss. We recommend treatment for MDD or complicated grief lasting 6 months post-loss or beyond. The delay in treatment minimizes the identification and treatment of false-positive cases of MDD or complicated grief—cases that would resolve without intervention. Obviously, immediate attention from a mental health professional should be sought if suicidality is suspected at any time post-loss.

When enduring psychopathology exists, we believe that a psychiatric referral can be very helpful. However, bereaved geriatric patients may be reluctant to see a mental health professional, preferring to be seen by their primary care physician.[58] Primary care physicians who acquire the requisite expertise in the treatment of psychiatric disorders can be effective.

HOW SHOULD BEREAVEMENT-RELATED PSYCHIATRIC COMPLICATIONS BE TREATED?

The results of an emerging body of literature on bereavement interventions suggest that treatment selection should depend on the patient's specific psychiatric diagnosis or diagnoses. For bereaved patients diagnosed with MDD alone, treatment should follow general guidelines,[59] including the prescription of selective serotonin reuptake inhibitors or tricyclic antidepressants. A randomized, placebo-controlled clinical trial of bereaved patients with MDD found nortriptyline alone had a 56% remission rate; nortriptyline in combination with interpersonal psychotherapy, 69%; and interpersonal psychotherapy alone, 29%.[27] An open-label trial of paroxetine, a selective serotonin uptake inhibitor, administered weekly over 4 months, demonstrated a 54% decline in symptoms of MDD.[60] Although a randomized controlled trial is needed to confirm the efficacy of selective serotonin reuptake inhibitors for MDD secondary to bereavement, MDD following the death of a loved one has been shown to be no different than other manifestations of MDD.[61] Consequently, treatments of proven efficacy for MDD would be expected to work well for the reduction of bereavement-related depressive symptoms.[56]

Results of studies documenting the reduction of grief-related symptoms (those targeting both earlier formulations of grief symptoms and complicated grief criteria, specifically) differ from those reported for bereavement-related MDD.[27,28] For example, the randomized controlled trial by Reynolds et al[27] of interpersonal psychotherapy and/or tricyclic antidepressants found that these treatments did not significantly reduce symptoms of complicated grief. Randomized controlled trials of crisis intervention[62] and brief dynamic psychotherapy[50,63] demonstrate significant reductions in grief symptoms, with support groups showing efficacy equal to that of dynamic psychotherapy.[50,63] In a small randomized controlled trial, a behavioral therapy called "guided mourning" significantly reduced symptoms of "morbid grief."[64] Another brief psychotherapy in development, called "traumatic grief therapy,"[65] is designed specifically to ameliorate symptoms of complicated grief and incorporates elements of cognitive behavioral therapy. In pilot work, traumatic grief therapy had large effect sizes (2.2 and 1.5 in analyses of completers and intent-to-treat patients, respectively) for reducing symptoms of complicated grief, with significant declines reported for symptoms of bereavement-related depression and anxiety. With respect to pharmacotherapy, the open-label trial of paroxetine demonstrated a 53% decline in symptoms of complicated grief. Based on these findings, it appears that traumatic grief therapy and selective serotonin reuptake inhibitors may be the treatments of choice, given their efficacy for reducing the symptoms of both complicated grief and MDD. Randomized controlled trials are needed before these recommendations can be made conclusively.

REWARDS OF BEREAVEMENT CARE

There are several compelling reasons for physicians to actively engage in bereavement care. First, they already are involved in caring for bereaved patients and will become increasingly so as the US population ages. Empathic "aftercare" for bereaved patients demonstrates the physician's respect for the deceased and concern for surviving family members. It may soften the psychological blow of losing a loved one and reduce the family's sense of abandonment by the health care system. Enhanced efforts to discuss the medical decisions and care leading up to the patient's final moments may assist both surviving family members and physicians in attaining a greater sense of closure. The detection and treatment of psychiatric complications secondary to bereavement may reduce the morbidity with which they are associated. Most importantly, as the introductory quote from George Eliot suggests, physicians who aid grief-stricken patients are afforded the rewarding, quintessentially human opportunity of transforming a personal sorrow they inevitably will experience into sympathetic and supportive "aftercare."

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Other Resources: For a list of relevant Web sites and books on bereavement, see the *JAMA* Web site at http://jama.ama-assn.org/issues/v286n11/abs/jel10000.html.

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Other Resources

Organizations and Internet Links on Bereavement

ARP
http://www.aarp.com
Information for individuals facing major life changes due to a loss, including "Coping With Grief and Loss" AARP Online Grief Support Discussions.

American Society of Psychosocial & Behavioral Oncology/ AIDS (ASPBOA)
http://www.ipos-aspboa.org
Multidisciplinary organization concerned with the recognition and research of the psychosocial and behavioral dimensions of cancer.

Bereavement and Hospice Support Netline
http://www.ubalt.edu/www/bereavement
An online directory of bereavement support groups and services and hospice bereavement programs across the United States.

The Compassionate Friends National Headquarters
PO Box 3696
Oak Brook, IL 60522-3696
Telephone: (312) 990-0010
Compassionate Friends assists family members who have lost a child.

Counseling For Loss & Life Changes
http://www.counselingforloss.com/
A grief support Web site for those suffering the loss of a loved one, including counseling services, personal journal entries, inspirational writings, professional services, a weekly column, and a column tailored to children, "The Children's Corner."

GriefNet
http://griefnet.org
GriefNet offers e-mail support groups about death, grief, and major loss, including life-threatening and chronic illness.

Growth House, Inc
http://www.growthhouse.org/death.html
Provides specialized resources for bereaved families, helping children grieve, pregnancy loss and infant death, and suicide. Specialized links provide additional resources for grief and terminal illnesses.

Hospice Foundation of America (HFA)
http://www.hospicefoundation.org/
Provides general resources and background information on hospices, and produces a number of educational programs including a National Bereavement Teleconference and an education audiotape series for clergy members.

Thanatolinks
http://www.lsds.com/death/
Links to some informative and useful sites related to death and dying.

The International THEOS Foundation (THEOS, They Help Each Other Spiritually)
322 Boulevard of the Allies, Suite 105
Pittsburgh, PA 15222-1919
Phone: (412) 471-7779
Fax: (412) 471-7782
Contact: Ramona Corey
THEOS is an organization that helps widowed men and women cope with losing their spouse. 120 local chapters which offer monthly meetings and one-on-one support services and numerous publications.

End-of-Life Physician Education Resource Center
http://www.eperc.mcw.edu
Online peer-reviewed information about instructional and evaluation materials (eg, lectures, small-group exercises, slide sets, videotapes, self-study guides, assessment tools) focused on the end of life.

Books on Bereavement

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